



Request for Prior Authorization
ALPHA2 AGONISTS, EXTENDED-RELEASE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for extended-release alpha2 agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age. 2) Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred (no PA required)

Non-Preferred (PA required)

[] Guanfacine ER

[] Clonidine ER

[] Intuniv

[] Kapvay

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____

Trial of preferred immediate release product of same chemical entity: Drug Name & Dose:

_____ Trial Dates: _____ Failure Reason: _____

Trial of preferred amphetamine stimulant: Drug Name & Dose:

Trial Dates: _____ Failure Reason: _____

Trial of preferred non-amphetamine stimulant: Drug Name & Dose: _____

Trial dates: _____ Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Table with 2 columns: Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.